has been tapered to 15 mg every other day, and she has continued to do very well clinically.

Recent publications have emphasized unusual presentations of polymyalgia rheumatica and temporal arteritis.[2,3] The above case shows that even the more traditional presentations can vary from patient to patient. A literature search has failed to find previous reports of palindromic or asymmetric polymyalgia rheumatica. Further definition of these variations and their frequency may be useful in allowing patients to receive therapy for this eminently treatable disorder.

ROBERT M. HEILIGMAN, MD
Family Practice Center
Antelope Valley Hospital Medical Center
Lancaster, California

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Women in House Staff Training Programs

TO THE EDITOR: Recent reports[1,2] have described the increased impact of women physicians in medicine. We would like to add another dimension to this reported experience by noting the prevalence of women in the house staff training programs at the Kaiser-Permanente Medical Center in Santa Clara, California. This hospital is part of Stanford University's affiliated programs for graduate medical education in pediatrics, general surgery and the surgical specialties, and has independent programs in obstetrics and gynecology and internal medicine (affiliated for medical student teaching).

The medical house staff consists of 22 full-time residents, 4 first-year residents in psychiatry from Stanford University, who spend six months on medicine, and a chief medical resident. Of the 22 full-time medical residents, 18 (82 percent) are women. Of this year's entering residents, 100 percent (all eight) are women. Women make up 44 percent (four of nine) of the obstetrics and gynecology house staff.

We can only speculate on the reasons for this prevalence. Chance probably is one factor. Another might be the noncompetitive and strong clinical orientation of the programs, or the flexible structure of the medicine program, which also allows considerable time for personal needs (night call every fifth night and a night float system, for example).

HENRY W. JONES III, MD
ELLIOTT S. WOLFE, MD
Department of Medicine
Kaiser-Permanente Medical Center
Santa Clara, California

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Iron Deficiency Therapy and General Nutrition

TO THE EDITOR: We commend the interesting and thorough paper "Iron Deficiency: Diagnosis and Treatment"[1] by Dr. Peter R. Dallman in the June 1981 issue. We would add only two precautionary notes from a nutritional point of view. First, iron therapy can affect the absorption of other essential nutrients[2] and for this reason should be lowered when the anemia is eradicated and discontinued as soon as the patient's iron stores are deemed adequate. Second, it must be remembered that the dietary recommendations in Dr. Dallman's paper pertain to patients with clinical problems and are not appropriate for the healthy, normal population. (For example, to limit dairy foods with an eye towards enhancing iron absorption would, in a person not at iron risk, limit access to calcium, riboflavin, and vitamins A and D, nutrients not abundantly available in our food supply otherwise.)

Dietary recommendations limiting the intake of any of the basic four food groups during iron therapy should be discontinued as soon as the iron deficiency has been eradicated, and the complete exclusion of any major food group during iron therapy should definitely be discouraged.

ANDREA ROSANOFF, MS
GEORGE M. BRIGGS, PhD
Department of Nutritional Sciences
University of California, Berkeley
Berkeley, California

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Competition and Professionalism

TO THE EDITOR: There is an increasing feeling of uneasiness in the current attempt to indoctrinate the practitioner with economic guideposts to his professional conduct. Such erosion of professionalism is implicit in a cold dollar-centered judgment of medical care—a judgment that does not reflect